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| **Personal Details** |
| Name | Date of birthMale [ ] Female [ ] |
| Easiest Contact telephone numberEmail |  |
| **Dates of trip** |
| Date of Departure |  |
| Return Date or overall length of trip |  |
| **Details about Destination** |
| Country & location to be visited | Length of Stay | Away from medical help, if so, how remote? |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| Do you plan to travel abroad again in the future? |
| **Please tick as appropriate below to best describe your trip** |
| 1. Type of trip | Business |  | Pleasure |  | Other |  |
| 2. Holiday type | Package |  | Self-organised |  | Backpacking |  |
| Camping |  | Cruise Ship |  | Trekking |  |
| 3. Accommodation | Hotel |  | Relatives/family home |  | Other |  |
| 4. Travelling | Alone |  | With family/friend |  | In a group |  |
| 5. Area is | Urban |  | Rural |  | Altitude |  |
| 6. Planned Activities | Safari |  | Adventure |  | Other |  |
| **Personal Medical History** |
| Do you have any recent of past medical history of note? (incl. diabetes, heart or lung conditions) |
| List any current or repeat medications |
| Do you have any allergies for example to eggs, antibiotics, nuts or latex? |
| Have you ever had a serious reaction to a vaccine given to you before? |
| Does having an injection make you feel faint? |
| Do you or any close family members have epilepsy? |
| Do you have any history of mental illness including depression or anxiety? |
| Have you recently undergone radiotherapy, chemotherapy or steroid treatment? |
| ***Women Only***: Are you pregnant or planning pregnancy or breastfeeding? |
| Have you taken out travel insurance and if you have a medical condition, informed the insurance company about this? |
| Please write below any further information which may be relevant |
| **Vaccination history** |
| Have you ever had any of the following vaccinations/malaria and if so when? |
| Tetanus |  | Polio |  | Diphtheria |  |
| Typhoid |  | Hepatitis A |  | Hepatitis B |  |
| Meningitis |  | Yellow Fever |  | Influenza |  |
| Rabies |  | Jap B Enceph |  | Tick Borne |  |
| Other |
| Malaria Tablets |

For discussion when risk assessment is performed within your appointment:

I have no reason to think that I might be pregnant. I have received information on the risks and benefits of the vaccines recommended and have had the opportunity to ask questions. I consent to the vaccines being given.

Signed: Date:

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| **FOR OFFICIAL USE** |
| Patient Name: |
| Travel risk assessment performed Yes [ ] No [ ] |
| **Travel Vaccines recommended for this trip** |
| Disease protection | Yes | No | Patient Declined Vaccine | Vaccine name, dose & schedule for PSD |
| Hepatitis A |  |  |  |  |
| Hepatitis B |  |  |  |  |
| Typhoid |  |  |  |  |
| Cholera |  |  |  |  |
| Tetanus |  |  |  |  |
| Diphtheria |  |  |  |  |
| Polio |  |  |  |  |
| Meningitis ACWY |  |  |  |  |
| Yellow Fever |  |  |  |  |
| Rabies |  |  |  |  |
| Japanese B Encephalitis |  |  |  |  |
| Other |  |  |  |  |
| Other |  |  |  |  |
| **Travel Advice and leaflets given as per travel protocol** |
| Food, water and personal hygiene advice |  | Travellers’ Diarrhoea |  | Blood and bodily fluid infection risks e.g. Hep B |  |
| Insect bite prevention |  | Animal bites |  | Accidents |  |
| Insurance |  | Air travel |  | Sun and heat protection |  |
| Websites |  | SMS vaccines reminder service set up |  |
| Travel record card supplied |  | Other |
| **Malaria prevention advice and malaria chemoprophylaxis** |
| Chloroquine and proguanil |  | Atovaquone + proguanil |  |
| Chloroquine |  | Mefloquine |  |
| Doxycycline |  | Malaria advice leaflet given |  |
| **Further information** |
| E.g. weight of child |
| **Authorisation for Patient Specific Direction (PSD) Use** |
| Name:  | Signature: | Date: |